The way in which healthcare services, including the UK’s National Health Service (NHS), are able to respond to the changing needs and preferences of older users will probably be the single most important test of whether we have fit-for-purpose, durable healthcare systems over the coming 10 to 20 years.

This agenda has moved from being something that deserved thought, to something which is inescapably important for policy makers and systems leaders in all healthcare systems, including the NHS. I’ve been asked to give you a quick glance of some of the things we’re thinking in terms of how we future proof our health services given the opportunities and challenges ahead. [...]

We in the NHS have recently produced the Five Year Forward View, which outlines the need for integration of primary and specialist services, integration of physical and mental health services and integration of health and social care services. Consequently, the agenda we’ve set ourselves is to make concrete steps forward on that triple integration to ensure the health services are rising to the challenge and the opportunity of an ageing population. [...]

We think there are four fronts on which we’ve got an opportunity to advance. The first is that care quality is highly variable. [...] The reason this is so important in the context of older people’s services is that it is older people who are our principal users of health and hospital services. [...] There is no doubt that standardising the quality of care, reducing unacceptable variations including, on occasion, age discrimination, will be a principal litmus test by which services are judged by the public.

The second front, a kind of flip-side to that, is while we want to standardise care and quality, we also want to personalise the care offer. For too many people in too many places, it is our users who have to fit themselves around particular components of care that the country has chosen to put in place, rather than the other way around. My sense is, and it’s certainly true in England, that we are looking at new ways to give patients more power in the way the services are organised around their own needs and preferences. [...] The third of my four fronts would be the need to move away from health services that are predominantly reactive – waiting for something to go wrong for people to visit the doctor’s office or A&E department and then figuring out what to do. In this country, as well as in a number of others, we have the design advantage of having population-based primary care. General practitioners can make it possible to prospectively plan the care that a patient might benefit from. In reality, however, this is one of the unexploited advantages of the NHS and we have not capitalised on the potential that model offers us. [...]

The fourth front is what we call ‘co-production’ – the idea that health services can’t do it all by themselves [...]. We need to recognise that the health service exists in a complex ecosystem of interactions and organisations in which the debate about the relationship between health services and social care is one that is ongoing. In this country, the estimated economic value of informal carers’ unpaid care at least matches, if not exceeds, the cost of the NHS itself. [...] We know we have about 110,000 people aged over 85 who are doing very substantial amounts of care for a spouse or relative. One of the things we’re going to try and figure out over the next several years is how we can make a better offer to carers to sustain them in those roles. [...]

The underlying point is that the NHS is aware that the big concept we’ve got to get right over the next five years is the support we offer to older people in this country. [...] We do best when we listen hardest and that’s the journey we’re now embarking on.